Attach student photo here

DIABETES MEDICATION ADMINISTRATION FORM [PART A]

Provider Medication Order Form – Office of School Health – School Year **2020-2021**

DUE: June 1st. Forms submitted after June 1st may delay processing for new school year. Please fax all DMAFs to 347-396-8932/8945

Student Last Name	First Name	MI	**Date of Birth**	☐ Male ☐ Female	**OSIS #**
School (include ATSDBN/name, address and borough)			**DOE District**	**Grade**	**Class**

HEALTH CARE PRACTITIONER COMPLETES BELOW *[Please see 'Provider Guidelines for DMAF Completion']*

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Non-Type 1/Type 2 Diabetes ☐ Other Diagnosis: _____

Recent A1C: Date __ __ / __ __ / __ __ __ __ Result _____.___%

Orders written will be for Sept. '20 through Aug '21 school year unless checked here: ☐ Current School Year '19-'20 and '20-'21

EMERGENCY ORDERS

Severe Hypoglycemia

Administer **Glucagon** and **call 911**

Glucagon: ☐ 1 mg ☐ ___ mg SC/IM

GVOKE: ☐ 1 mg ☐ ___ mg SC/IM

Baqsimi: ☐ 3 mg Intranasal

Give PRN: unconscious, unresponsive, seizure, or inability to swallow EVEN if bG is unknown. Turn onto left side to prevent aspiration.

Risk for Ketones or Diabetic Ketoacidosis (DKA)

☐ Test **ketones** if bG > ____ mg/dl, or if vomiting, or fever > 100.5F

OR

☐ Test ketones if bG > __ mg/dl for the 2nd time that day (at least 2 hrs. apart), or if vomiting or fever > 100.5F

- If small or trace give water; re-test ketones & bG in 2 hrs or ___ hrs
- If ketones are moderate or large, give water:
  Call parent and Endocrinologist; ☐ **NO GYM**
  If ketones and vomiting, unable to take PO and MD not available, **CALL 911**

☐ Give insulin correction dose if > 2 hrs or __ hours since last insulin.

SKILL LEVEL

Blood Glucose (bG) Monitoring Skill Level

☐ Nurse / adult must check bG.

☐ Student to check bG with adult supervision.

☐ Student may check bG without supervision.

Insulin Administration Skill Level

☐ Nurse-Dependent Student: nurse must administer medication

☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: self-carry / self-administer *(MUST Initial attestation)*
I attest that the **independent** student demonstrated the ability to self-administer the prescribed medication effectively for school, field trips, & school/sponsored events

PROVIDER INITIALS

NOTE: Trip nurse not required for supervised or independent students.

BLOOD GLUCOSE MONITORING *[See Part B for CGM readings]*

Specify times to test in school (must match times for treatment and/or insulin) ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN

Hypoglycemia: *Check all boxes needed. Must include at least one treatment plan.*

☐ T2DM - no bG monitoring or insulin in school

☐ For bG < _____ mg/dl give _____ gm rapid carbs at: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN
Repeat bG testing in 15 or ____ min. If bG still < _____ mg/dl repeat carbs and retesting until bG > _____ mg/dl.

15 gm rapid carbs = 4 glucose tabs = 1 glucose gel tube = 4 oz.

☐ For bG < _____ mg/dl give _____ gm rapid carbs at: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN
Repeat bG testing in 15 or ____ min. If bG still < _____ mg/dl repeat carbs and retesting until bG > _____ mg/dl.

☐ For bG < _____ mg/dl pre-gym, **no gym** ☐ For bG < _____ mg/dl ☐ Pre-gym; ☐ PRN; treat hypoglycemia then give snack.

Snack orders on DMAF Part B

Insulin is given before food unless noted here: ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack

Mid-range Glycemia: *Insulin is given before food unless noted here:* ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Give snack before gym

Hyperglycemia: *Insulin is given before food unless noted here:* ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack

☐ No Gym For bG > ___ mg/dl ☐ Pre-gym and/or ☐ PRN

☐ For bG > ___ mg/dl PRN, Give insulin correction dose if > 2 hrs or __ hrs since last insulin ☐ For bG meter reading "**High**" use bG of 500 or___ mg/dl.

☐ **Check bG or Sensor Glucose (sG) before dismissal**

☐ Give correction dose pre-meal and carb coverage after meal

☐ For sG or bG values < ___ mg/dl treat for hypoglycemia if needed, and give ___ gm carb snack before dismissed

☐ For sG or bG values <___ mg/dl treat for hypoglycemia if needed, and do not send on bus/mass transit, parent to pick up from school.

INSULIN ORDERS

Name of Insulin*:

_____

* May substitute Novolog with Humalog/Admelog

☐ No Insulin in School

☐ No Insulin at Snack

Delivery Method:

☐ Syringe/Pen

☐ Pump *(Brand)*:

_____

☐ Smart Pen – use pen suggestions

Insulin Calculation Method:

☐ Carb coverage **ONLY** at: ☐ Breakfast ☐ Lunch ☐ Snack

☐ Correction dose **ONLY** at: ☐ Breakfast ☐ Lunch ☐ Snack

☐ Carb coverage **plus** correction dose when bG > Target **AND** at least 2 hrs or ___ hrs. since last insulin at ☐ Breakfast ☐ Lunch ☐ Snack
Correction dose calculated using: ☐ ISF **or** ☐ Sliding Scale

☐ Fixed Dose *(see Other Orders)*

☐ Sliding Scale *(See Part B)*

☐ If gym/recess is immediately following lunch, subtract ___ gm carbs from lunch carb calculation.

Insulin Calculation Directions: *(give number, not range)*

Target bG = _____ mg/dl

Insulin Sensitivity Factor (ISF):
1 unit decreases bG by ___ mg/dl
(time: _____ to _____)
1 unit decreases bG by ___ mg/dl:
(time: _____ to _____)

If only one ISF, time will be 8am to 4pm if not specified.

Insulin to Carb Ratio (I:C):

Bkfast **OR** time: ____ to ____
1 unit per ___ gms carbs

Snack **OR** time: ____ to ____
1 unit per ___ gms carbs

Lunch **OR** time: ____ to ____
1 unit per ___ gms carbs

Lunch followed by gym
1 unit per ___ gms carbs

Carb Coverage:	**Correction Dose using ISF:**	Round DOWN insulin dose to closest 0.5 unit for syringe/pen, or nearest whole unit if syringe/pen doesn't have ½ unit marks; unless otherwise instructed by PCP/Endocrinologist. Round DOWN to nearest 0.1 unit for pumps, unless following pump recommendations or PCP/Endocrinologist orders.
# gm carb in meal = X units insulin # gm carb in I:C	bG – Target bG = X units insulin ISF	

For Pumps - Basal Rate in school:

__:___ AM/PM to __:__ AM/PM _____ units/hr

__:___ AM/PM to __:__ AM/PM _____ units/hr

__:___ AM/PM to __:__ AM/PM _____ units/hr

☐ Student on FDA approved hybrid closed loop pump-basal rate variable per pump.

☐ Suspend/disconnect pump for gym

☐ Suspend pump for hypoglycemia not responding to treatment for ____ min.

Additional Pump Instructions:

☐ Follow pump recommendations for bolus dose *(if not using pump recommendations, will round down to nearest 0.1 unit)*

☐ For bG > ___ mg/dl that has not decreased in __ hours after correction, consider pump failure and notify parents.

☐ For suspected pump failure: SUSPEND pump, give insulin by syringe or pen, and notify parents.

☐ For pump failure, only give correction dose if > __ hrs since last insulin

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS **FORMS CANNOT BE COMPLETED BY A RESIDENT** Rev 4/20

HEALTH CARE PRACTITIONERS: COMPLETE 'PART B' AND SIGN ➔

Student Name (Last, First): _____, _____ OSIS Number: _____

DIABETES MEDICATION ADMINISTRATION FORM [PART B]

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CONTINUOUS GLUCOSE MONITORING (CGM) ORDERS *[Please see 'Provider Guidelines for DMAF Completion']*

☐ Use CGM readings - For CGM's used to replace finger stick bG readings, only devices FDA approved for use and age may be used within the limits of the manufacturer's protocol. (sG = sensor glucose).

Name and Model of CGM: _____

For CGM used for insulin dosing: finger stick bG will be done when: the symptoms don't match the CGM readings; if there is some reason to doubt the sensor (i.e. for readings <70 mg/dl or sensor does not show both arrows and numbers)

☐ CGM to be used for insulin dosing and monitoring - **must be FDA approved for use and age**

sG Monitoring Specify times to check sensor reading: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN [*if none checked, will use bG monitoring times]*
For sG <70mg/dl check bG and follow orders on DMAF, unless otherwise ordered below.
Use CGM grid below OR ☐ See attached CGM instruction

CGM reading	Arrows	Action ☐ use < 80 mg/dl instead of < 70 mg/dl for grid action plan
sG < 60 mg/dl	Any arrows	Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still < 70 mg/dl check bG.
sG 60-70 mg/dl	and ↓, ↓↓, ↘ or →	Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still < 70 mg/dl check bG.
sG 60-70 mg/dl	and ↑ , ↑↑, or ↗	If symptomatic, treat hypoglycemia per bG hypoglycemia plan; if not symptomatic, recheck in 15-20 minutes. If still <70 mg/dl check bG.
sG >70 mg/dl	Any arrows	Follow bG DMAF orders for insulin dosing
sG ≤ 120 mg/dl pre-gym or recess	and ↓, ↓↓	Give 15 gms uncovered carbs. If gym or recess is immediately after lunch, subtract 15 gms of carbs from lunch carb calculation.
sG ≥ 250	Any arrows	Follow bG DMAF orders for treatment and insulin dosing

☐ For student using CGM, wait 2 hours after meal before testing ketones with hyperglycemia.

PARENTAL INPUT INTO INSULIN DOSING

☐ Parent(s)/Guardian(s) (*give name*), _____, may provide the nurse with information relevant to insulin dosing, including dosing recommendations. Taking the parent's input into account, the nurse will determine the insulin dose within the range ordered by the health care practitioner and in keeping with nursing judgment.

Please select **one** option below:

1. ☐ Nurse may adjust calculated dose up or down up to __ units based on parental input and nursing judgment.

2. ☐ Nurse may adjust calculated dose up by ___% or down by ___% of the prescribed dose based on parental input and nursing judgment

MUST COMPLETE: **Health care practitioner can be reached for urgent dosing orders at: (__ __ __) __ __ __ - __ __ __ __**
If the parent requests a similar adjustment for > 2 days in a row, the nurse will contact the health care practitioner to see if the school orders need to be revised.

SLIDING SCALE

Do NOT overlap ranges (e.g. enter 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given. Use pre-treatment bG to calculate insulin dose unless other orders.

	bG	Units Insulin		bG	Units Insulin
☐Lunch	Zero - ____	_____	☐Other	Zero - ____	_____
☐Snack	____ - ____	_____	Time	____ - ____	_____
☐Breakfast	____ - ____	_____	_____	____ - ____	_____
☐Correction	____ - ____	_____	☐Snack	____ - ____	_____
Dose	____ - ____	_____	☐Breakfast	____ - ____	_____
	____ - ____	_____	☐Correction	____ - ____	_____
	____ - ____	_____	Dose	____ - ____	_____

OPTIONAL ORDERS

☐ Round insulin dosing to nearest whole unit: 0.51-1.50u rounds to 1.00u.
☐ Round insulin dosing to nearest half unit: 0.26-0.75u rounds to 0.50 u (must have half unit syringe/pen).
☐ Use sliding scale for correction AND at meals ADD: __units for lunch; __ units for snack; __ units for breakfast (sliding scale must be marked as correction dose only).
☐ Long acting insulin given in school – Insulin Name: _____
Dose: ____ units Time _____ or ☐ Lunch

SNACK ORDERS

☐ Student may carry and self-administer snack
Snack time of day: ___ AM / PM ☐ Pre-gym Snack
Type & amount of snack: _____

OTHER ORDERS:

HOME MEDICATIONS

Medication	Dose	Frequency	Time	Route
Insulin:				
Other:				

ADDITIONAL INFORMATION

Is the child using altered or non-FDA approved equipment? ☐ Yes or ☐ No [*Please note that New York State Education laws prohibit nurses from managing non-FDA devices. Please provide pump-failure and/or back up orders on DMAF Part A Form.]*

By signing this form, I certify that I have discussed these orders with the parent(s)/guardian(s).

Health Care Practitioner Name LAST FIRST		Signature	
(**Please print and check one:** ☐ MD, ☐ DO, ☐ NP, ☐ PA)			Date __ __ / __ __ / __ __ __ __
Address		Tel. (__ __ __) __ __ __ - __ __ __ __	Fax. (__ __ __) __ __ __ - __ __ __ __
NYS License # **(Required)**	E-mail	**CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.**	

FOR PRINT USE ONLY | Confidential Information should not be sent by email.

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PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to the nurse giving my child's prescribed medicine, and the nurse/trained staff checking their blood sugar and treating their low blood sugar based on the directions and skill level determined by my child's health care practitioner. These actions may be performed on school grounds or during school trips.
2. I also consent to any equipment needed for my child's medicine being stored and used at school.
3. I understand that:
   - I must give the school nurse my child's medicine, snacks, equipment, and supplies and must replace such medicine, snacks, equipment and supplies as needed. OSH recommends the use of safety lancets and other safety needle devices and supplies to check my child's blood sugar levels and give insulin.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - Prescription medicine must have the original pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the health care practitioner's instructions.
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this Medication Administration Form (MAF), I authorize OSH to provide diabetes-related health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. OSH will not need my signature for future MAFs.
   - OSH and the Department of Education (DOE) are responsible for making sure that my child can safely test his or her blood sugar.
   - This form represents my consent and request for the diabetes services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment for my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

OSH Parent Hotline for questions about the Diabetes Medication Administration Form (DMAF): 718-310-2496

FOR SELF-ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving them the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give them medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.
- I consent to the school nurse or trained school staff giving my child Glucagon if prescribed by their health care provider if my child is temporarily unable to carry and take medicine. **This does not include nasal Glucagon as New York State does not endorse training non-licensed personnel to administer nasal Glucagon at this time.**

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

Student Last Name	**First Name**	**MI**	**Date of Birth** __ __ / __ __ / __ __ __ __

School ATSDBN/Name	**Borough**	**District**

Print Parent/Guardian's Name	**Parent/Guardian's Signature for Parts A & B**	**Date Signed**
	SIGN HERE	__ __ / __ __ / __ __ __ __

Parent/Guardian's Email

Parent/Guardian's Address

Telephone Numbers: **Daytime** (__ __ __) __ __ __-__ __ __ __ **Home** (__ __ __) __ __ __-__ __ __ __ **Cell Phone** (__ __ __) __ __ __-__ __ __ __

Alternate Emergency Contact's Name	**Relationship to Student**	**Contact Telephone Number**
		(__ __ __) __ __ __-__ __ __ __

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For Office of School Health (OSH) Use Only

OSIS Number:

Received by: Date _ _/_ _/_ _ _ _

Reviewed by: Date _ _/_ _/_ _ _ _

☐ **504** ☐ **IEP** ☐ **Other** **Referred to School 504 Coordinator**: ☐ Yes ☐ No

Services provided by: ☐ Nurse/NP ☐ OSH Public Health Advisor (for supervised students only) ☐ School Based Health Center

Signature and Title (RN OR SMD):

Date School Notified & Form Sent to DOE Liaison _ _ / _ _ / _ _ _ _

Revisions as per OSH contact with prescribing health care practitioner ☐ Modified ☐ Not Modified

Notes: